

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:
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# Certified End Page

**PUNXSUTAWNEY AREA HOSPITAL, INC.**

**STATE LICENSE NUMBER: 163701**

**SURVEY EXIT DATE: 05/11/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY